MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Wednesday, November 17, 2004
1:00 PM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Wednesday, November 17, 2004 at 1:00 P.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Cecil Hargett, and William Purcell and Representatives Martha Alexander, Jeffrey Barnhart, Beverly Earle, Carolyn Justice, Edd Nye, John Sauls and Paul Stam.

Dr. Alice Lin, Project Manager, Jim Klingler, Kory Goldsmith, Shawn Parker and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. He began by commenting on the success of the Child Services Task Force Information meeting that took place that morning. He told members that all the agencies representing children's services were present to discuss collaboration. He felt that collaboration was taking place at all levels, but that it was critical that it be effective at the local level. Senator Nesbitt said the Task Force would meet again in December and that in order for the LOC to complete it's assigned work before Session in January, we would need to meet several more times.

Senator Nesbitt asked for a motion for the approval of the minutes from the September 29th meeting. The motion was made and the minutes were approved.

Senator Nesbitt called on Mike Moseley, Director of the Division of Mental Health, Developmental Disabilities and Substance Services for an update. Mr. Moseley announced that Dr. Stanley Slawinski has accepted another position in the Department and is no longer serving as Chief of State Operated Services. Michael Hennike will act as Interim Chief through the coming Session, at which time a permanent Chief will be announced. Also, Don Willis is retiring effective the end of December. He said that Dr. Michael Lancaster's presentation on Target/Non Target Populations today would probably be the beginning of an ongoing discussion. He also said that the Science to Service Project that Beth Melcher was reporting on is a project contracted for and supported by the Division. The Division is currently looking at recommendations by Dr. Melcher and will respond shortly so they can continue to work together to move the system forward.

Representative Alexander, Co-Chair of the DWI/ADET Advisory Committee, gave a brief report on activities of the committee. She said the committee is studying the ADET facilities and the fee structure as directed by legislation passed last Session. She said those conducting a survey to gather data, are speaking directly with the fifty-two facilities in order to get a more accurate response. She explained there was concern across the State regarding DWI. The Governor has a Task Force looking at the issue, but the LOC subcommittee is specifically examining the ADETs.

Jim Klingler, Fiscal Analyst, gave an overview of the budget for community mental health, developmental disabilities and substance abuse services and the allocation of State appropriations. (See Attachment No. 2) He told members that of the $1.6 billion in the state's MHDDSA budget, Medicaid pays 65% of all services delivered in the community; this includes payment to area programs or LMEs and providers. The State appropriates 20% of that amount. He said that just over $1 billion flows through the area programs with 49% coming from Medicaid. The difference is that the Medicaid funds are paid to direct enrolled Medicaid providers. With changes in the amendment to the State Plan in development, post reform, all Medicaid providers will be direct enrolled which would cause significantly more money to flow from the State and the State Medicaid Program to providers and not through the area programs.

Continuing, Mr. Klingler stated that the greatest change in the budget figures had been in the growth of Medicaid payment for services (122%) over the past five years. Senator Purcell asked for the reason for this significant growth. Mr. Klingler stated that mental health spending accounted for the increase. He said that annually mental health spending in the Medicaid program has been growing at roughly 24%-26% per year for the past five years, but inflation in the whole Medicaid program was about 13%-14% per year. High-risk intervention services for children have increased significantly over the years and have been a major cost driver. Senator Nesbitt asked why State spending had not gone up proportionally to match Medicaid. Mr. Klingler said Medicaid was an entitlement program. State dollars are not entitled, therefore, are limited by the budget provided by the General Assembly and will grow only if additional dollars are granted. Mr. Moseley added that in addition to residential treatment services, community based services are a source of growth in the Medicaid program. Representative Nye expressed concern over the cost of keeping people in group homes. Mr. Moseley explained that residential treatment for children was a relatively new service costing in excess of $200 million. The higher the level of need for services, the higher the cost and the more the reimbursement. The Division is currently looking at the service model realizing there are gaps and issues with respect to eligibility and provider qualifications.

Senator Purcell asked Mr. Moseley to explain a typical group home. Mr. Moseley said generally it's a small environment serving 3-5 individuals with staffing based on need. One problem with the clinical based model is that children are often admitted into facilities when they do not necessarily require the intensity of the treatment that is being paid for. On the other hand, youth may need residential treatment at that level but staff lack competency to address the needs. He said the Division is currently looking at these

issues and that with the new service definitions being based on best practice treatments, more youth will be able to move into the community.

Representative Insko asked the average stay for a child in a Level III group home. Flo Stein answered that she would get the data, but that the stay was much longer than intended. The new Child Mental Health Plan addresses services in the community, with more in-home emergency or respite care and the Plan reduces the use of out-of-home residential placement.

Senator Nesbitt asked if the Level I, II, and III homes are being over used and if they are larger than originally intended. Mr. Moseley responded that previously there were no residential options. With the new Service Definitions, which should generate additional Medicaid revenue, it is the intent to create a community-based system that will keep children in their local communities. The Division is trying to have wrap-around services in place to address this problem.

Representative Justice asked if the cost of group homes was greater than other treatment options and whether the kids were getting better. Senator Nesbitt noted that for those children who had previously been held in the Juvenile Justice system, that expense was greater. As children have moved out of the juvenile system into group homes, the numbers of group homes have proliferated. Dr. Michael Lancaster said that part of mental health reform is to have children treated in their communities and within their families as much as possible rather than in residential facilities. Therefore, the focus is to put family-based services in the communities so children can be raised in that environment.

Representative Nye asked if there was a collapse in oversight by the Department of Level III group homes. Mr. Moseley said Secretary Hooker Odom is overseeing the effort to review the regulatory climate connected to these programs and other residential programs and provider qualifications. The Department is seeking to put in place alternatives to correct effectiveness and cost efficiency. Because issues span different divisions within the Department, the Secretary plans to present a regulatory package to the Legislature this coming Session addressing rules, licensure issues, statutory oversight, regulatory issues, and provider qualifications.

Returning to the funding allocation presentation, Mr. Klingler reviewed the direct State appropriations to the area programs for the delivery of services. He noted that State appropriations are the main source of funding for indigent care and services not covered by Medicaid and that the funds are not equitably distributed across the area programs. Senator Nesbitt asked if anyone was looking at the inequitable distribution across the area programs. Mr. Klingler said that DHHS had been instructed by the General Assembly to report on a revised system for allocating State and federal funds to area mental health authorities and county programs that reflect projected needs. That report is due on February 1, 2005.

Mr. Klingler continued by explaining that Medicaid funding presents the largest single source of funding for area programs. The Federal Government pays $0.631/2 on every dollar expended for Medicaid reimbursable services. If a state's mental health system mirrors the Medicaid Policy, it can impact low-income individuals who are not Medicaid eligible. He pointed out that if the entire system shifts to a fully funded Medicaid program, indigent care would suffer. Senator Nesbitt noted that this was an important issue. Medicaid does not cover everyone that is poor unless they fall into a disability category. Senator Allran asked about the qualifications for someone receiving Medicaid. Mr. Klingler said he had a graph from DMA outlining the eligibility groups and the requirements of those groups that he would distribute to members. (See Attachment No. 3) He also pointed out policy changes under reform that would impact the cost of the Medicaid program, and noted that increased use of Medicaid will have an impact on the State and county budgets.

Mr. Klingler then reviewed a chart that illustrated the variation to area programs on per capita bases encompassing all funds. He noted that Pathways had a $260 per capita expenditure compared to the statewide payment of $125 and Johnston County had received $71. Representative Earle asked if services offered could cause the difference in expenditures. Mr. Klingler said a correlation has not been drawn to determine what is driving the variation. He said the number of Medicaid eligible clients could drive expenditures in an area, as could the client mix – some disabilities are more services are more costly to provide but not available in all areas.

Representative Sauls asked for a list of the alcohol and drug treatment centers in the State. Mr. Klingler told him they were the Blackley Center in Butner, Walter B. Jones in Greenville, and Julian Keith in Black Mountain. Senator Nesbitt stated that there was a six-week waiting period at the Keith Center and asked if the others had waiting lists. Ms. Wainwright said that Butner did not have a waiting list. Looking to Mr. Moseley for confirmation, Senator Nesbitt stated that at the present time those centers were not downsizing. Mr. Moseley said they were looking at the future mission of those facilities with the LMEs.

Mr. Klingler then explained the allocation of State funds and how they vary across the State per capita and per person served, and possible explanations for the variations in State expenditures. Representative Nye asked if the figure shown for Wake County included expenditures for patients at Dix Hospital. Mr. Klingler responded that the figure shown did not reflect expenditures at the State level for services, so that would have to be added to obtain the total cost. He then gave some long-term and short-term options for consideration when looking at a new allocation system and questions that should be considered regarding the system. He emphasized that options listed were simply ways to approach the issue of methodologically infusing more dollars. Amounts used could be capped and used in a different way.

Senator Nesbitt said the statistics indicate the system needs to be examined and that we need to be able to explain the formula for services to people or we need to revamp it. Senator Purcell asked if the Department was responsible for the new allocation system or

this committee. Mr. Klinger said the 2003 Appropriations Bill directed DHHS to make a report to the LOC in February 2005. The committee has the oversight responsibility on how reform occurs. Senator Nesbitt indicated that with the definitions and fees not coming out until January 2005 and with implementation occurring in July, it would be imperative that the committee hold monthly meetings during Session in order to review the work of the Department.

Regarding the Medicaid handout, Senator Allran asked about the requirements for Supplemental Security Income (SSI) eligibility. Carol Shaw from Fiscal Research said the eligibility requirement is 74% of the Federal poverty level. For one person it would be a little less than $9,000 annual income. In addition, a person must be 65 or older or be disabled to qualify for SSI. Those people receiving SSI automatically receive Medicaid.

Senator Allran further inquired about the Medicaid budget and how much was State and county money. Ms. Shaw said the total Medicaid budget this year is estimated to be $8.2 billion. The State share is $2.5 billion and the county share is $445-450 million.

Dr. Beth Melcher, Director of the North Carolina Science to Service Project, gave a presentation on the implementation of evidence-based practices for adults with mental illness. (See Attachment No. 4) She said she wanted to focus on what she believed to be the core of reform – access to services that support people in their lives, their recovery, and that allows them to stay in their communities. Dr. Melcher reviewed the Federal studies, initiatives, and goals. Evidenced Based Practices offers standardized treatments. She said controlled research has been done on services, with objective outcome measures, and there has been more than one active research group. She said Evidenced Based Practices offers mental health consumers choices of outcomes from services offered.

Dr. Melcher said information gathered from studies and surveys informed the recommendations compiled into a final report from the North Carolina Science to Service Project, published in July 2004. Half of the report is documentation from the baseline done with focus groups, families, consumers and surveys. The other half of the report is recommendations. Three goals were the focus of the report: 1) How to help stakeholders understand, know about and advocate for Evidence-Based Practices; 2) How to prepare the providers of these practices, how to train them, how to work with graduate schools to prepare new professionals, how to supervise, and how to create new models of training; and 3) Identify the kinds of things needed to create an infrastructure for implementation and be able to maintain it, including financing, data systems, outcomes, and infrastructures to promote quality improvement systems. She concluded her presentation by highlighting several recommendations and suggested that the report could be reviewed in its entirety on their web site, www.ncs2s.org.

Representative Stam asked who determines what is an Evidence Based Practice for payment. Dr. Melcher said that payment is not linked at this time to Evidence Based or not Evidence Based Practice. He followed by asking if we would pay for practices that are not based on peer review. Dr. Melcher said they had articulated in the State Medicaid Plan and the State Services Plan a list of services that the State will pay for. Some

services on that list have not reached the highest level of Evidence Based Practices, which means they are still being evaluated and we are gathering information to evaluate their effectiveness. The Service Definitions will offer a way to fund and pay for Evidence Based Practices. The new Service Definitions create the opportunity to provide the mechanism for these services that currently we are unable to pay for. She added that an Advisory Group was needed to review what is evidence based, and what are we going to endorse in North Carolina as Evidence Based, what shows promise that we might further research in order to get to the Evidence Based status.

Senator Purcell asked if Evidence Based Practices would save North Carolina money and Medicaid expenses. Dr. Melcher said the premise of Evidence Based Practice is to do the work to identify those things that are successful. Through Evidenced Based Practices, you understand whom the practice is for, see that people are receiving the services they are supposed to, that you target clinical accountability, and hold people accountable to provide the services the way they are meant to be. She said we would have to determine a way to measure cost savings, but certainly the services will be more effective.

Senator Nesbitt said the Department would respond to Dr. Melcher's presentation at the next meeting.

The meeting adjourned at 3:50 P.M.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant